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BULLYING IN THE NZ SENIOR MEDICAL WORKFORCE: WHAT THE SURVEY DOES NOT ADDRESS

DR CHARLOTTE CHAMBERS | ASMS PRINCIPAL ANALYST (POLICY & RESEARCH)

Enclosed with this month's issue of *The Specialist* is the latest *Health Dialogue* produced by the ASMS, which details the prevalence and consequences of workplace bullying for the ASMS membership.

The purpose of this research was three-fold. Primarily it sought to benchmark how many ASMS members are affected by this destructive phenomenon, as very little research has been conducted into consultants and specialists as victims of bullying. Secondly, we wanted to know if there are certain groups of members at greater risk of experiencing bullying and negative behaviours. Finally, we wanted to understand how well systems are functioning that deal with bullying complaints; what proportion of victims report their bullying, and if they choose not to report, what discourages them from doing so?

The results from this survey detailed the hitherto unknown prevalence of workplace bullying for the senior medical workforce and the distressing consequences of this phenomenon for senior doctors and dentists.

Significantly, the research found strong associations between heavy work demands, low peer and non-clinical managerial support and increased prevalence of bullying across all three measures of bullying used in the research. This strongly suggests that bullying is, as with the prevalence of burnout and presenteeism, another symptom of a stressed and stretched workforce. The foreword from the ASMS President Hein Stander emphasises this point.

Importantly, however, there are many issues associated with bullying that the *Health Dialogue* does not address but which are of relevance to the topic. Some of these include but are not limited to the issue of vexatious complaints, professional jealousy as a form of bullying, and the consequences of being accused of bullying for professional and personal lives. Due to the constraints of the survey, it was not possible to address these issues, but the *Bullying Standpoint* produced by the ASMS does provide important guidance for people who find themselves dealing with such situations.

Additional issues were raised in comments left in the survey as well as in email correspondence from members. In this article, I want to share some of the emails for which I've been given permission to cite, suitably anonymised. Again, I do not have all the answers to the issues raised, but I hope that in sharing these perspectives and concerns the discussions and debates can continue.

BULLYING IS SO ENTRENCHED, NOTHING WILL CHANGE

A number of members wrote in to express their frustration with the endemic nature of bullying in their workplaces and to suggest that despite best efforts, little was likely to change. Some wrote in to state that their DHBs were completely "non-responsive" to concerns raised, and others reported incidents where employees were requested to withdraw complaints. One member stated forcefully that:

"Nothing you find out will change the culture of management at our public hospitals. You have no mandate to make them change. So I can tell you right now that management at [hospital] is appalling and there is a culture of bullying. But if I wanted to change anything I'd need my own QC, an unlimited budget and sacrifice two years of my life to change anything. That's why I won't be filling out your survey, and neither will most of my colleagues. NOTHING you do will make them change. Sad but true."

The results strongly suggest that bullying is, as with the prevalence of burnout and presenteeism, another symptom of a stressed and stretched workforce.

Given the attention to bullying after the 2015 findings of the Royal Australasian College of Surgeons (RACS) regarding the high prevalence of bullying and harassment in surgery and the considerable efforts of the ASMS to encourage better awareness as to bullying and how to address it, this is pertinent data. These sentiments emphasise the pernicious and systemic consequences of working in negative workplace environments where, faced with such negativity, some may feel that little is likely to change.

Contrary to the views expressed by the member in this email, however, there is progress in many areas, including work to improve workplace culture so that negative behaviours are recognised and reported, and that such reports are acted upon. The ASMS is continuing to investigate different systems for reporting bullying, such as the Vanderbilt model, which emphasises prevention as the best cure. Industrial staff continue to monitor progress on this issue.

"I don't get aggression or bullying from staff but I am exposed to many of the things you ask [in the survey] from patients. Is it not important to clarify the difference?"

This valid point was raised by a renal specialist, and a similar query was raised by another ASMS member who worked in mental health.

The renal specialist wrote in to note that they received:

"Frequent abuse (yelling, swearing, sexual remarks), threats ('I will get you', 'I will burn your house down', 'I will report you/go to the media') and intimidation (invading personal body space) … Bad behaviour from patients is exhausting – both emotionally and the time requirements to deal with it. There is so much emphasis on patients' rights and little focus on their responsibilities. The DHB management are very supportive but the options for dealing with this are limited … I have not experienced bullying [from colleagues] at work. Quite the contrary. Other staff provide mutual support to get through this. If it were not for the cohesive team we work in, I would have quit long ago."

The difference between bullying and abuse from patients and their families is difficult to disentangle, but based on the definition of bullying used in the survey – "Bullying at work refers to situations where one or more persons feel subjected to negative and/or aggressive behaviour from others in the workplace over a period of time and in a situation where they for different reasons are unable to defend themselves against these actions" – receiving aggressive behaviour from patients would still be classed as a form of bullying. Other respondents noted that they had received negative behaviour from patients; just over 20% of respondents cited patients as the main perpetrators of their bullying.

As suggested in the correspondence above, bullying/abuse from patients is clearly challenging for those dedicated to providing patient care. Regardless, it is clear to the ASMS that it is an employer's responsibility to ensure that all staff can work in a safe workplace where they do not have to face abuse and aggressive behaviours from anyone with whom they may interact with at work.

BULLYING VS NEGATIVE FEEDBACK IN CLINICAL TEACHING ENVIRONMENTS

I received the following email from a member who raised a very important point about the difference between giving negative feedback in teaching environments, and how this can either escalate into bullying or be mislabelled as bullying behaviour. The key point raised is how to improve systems and skills sets to facilitate feedback in such a way without using the 'b' word, which, in the view of the member, can invoke a 'sledgehammer' solution to a problem that is far more subtle and nuanced. As the email states:

"I am aware that having been brought up in the current system, I may have blind spots about what constitutes bullying as being normalised behaviour. The issue I'm grappling with in regard to bullying is related to gender and expectation and perception. It is generally in a clinical teaching environment. The intent is to provide worthwhile teaching, but the delivery is sometimes too intense or escalates to this, particularly where the teaching is perceived as lacking value by the trainee or the teacher is not perceived as being worth listening to and the advice is rejected. What is perceived as bullying may then occur in a public way and reflect the distress of the teacher at being unable to teach. Personally when this occurred for me, I was able to firstly conduct the conversation in private and secondly walk away without ranting and conduct the conversation with a more enquiring 'why is what I'm teaching you not perceived as having value?', but others have been in similar circumstances and not done this. In many cases, it is female trainees and female specialists who are getting caught in this loop and the stronger the individual personalities involved, the more intense it all becomes and the more likely that it is called bullying behaviour … In contrast, males behaving badly are much less likely to be called because the conversation is too hard. They generally get moved sideways to avoid harm … what I'm worried about is the fact that at the lesser end of the spectrum, arguably 80% of events are being mishandled or called wrongly because there is no skill in disarming from situations which are essentially examples of miscommunication, misperception, gender bias and distress. We need to become much better skilled at dealing with this. The level of training and personal development needed is much higher than for those dealing with the easy extreme."

There are several issues encapsulated in these comments; firstly, the issue of how to provide feedback in an appropriate manner without escalation or being accused of bullying behaviour. As the member notes, it is important to be able to provide appropriate feedback in a constructive manner. As they suggest, there is potentially considerable scope to improve communication skills through training and personal development.

The ASMS notes the work that various colleges are doing in this space and commend their efforts. While many of the same skills are likely to be relevant for people who do have issues with bullying behaviour, labelling the situation as 'bullying' without considering the wider dynamic may miss the point.

The ASMS has been working hard to put forth better systems to deal with accusations of bullying, including encouraging intervention at the lowest possible level – a simple conversation. Such an approach is less likely to escalate a situation that could be readily addressed by a quiet word and possibly some personal development training – for example, how to provide constructive feedback.

The second issue raised by the member is the possibility that there may be a gender bias in how feedback is received, with

DR CHARLOTTE CHAMBERS

the result that women may be 'called out' as bullies more readily than their male counterparts in such circumstances. While the experience of the industrial team does not suggest a trend in this regard, the literature supports the possibility that there can be an issue with same-sex bias. Bruce et al (2015) find in a review that "women find women in leadership positions to be less qualified and less desirable than identically described men" and further that "successful women in male domains were less liked and more likely to be attributed to undesirable interpersonal qualities" such as assertiveness and agency as a leader (p7). Unfortunately, due to the limitations of a survey approach, these issues were not directly investigated in the survey. Nevertheless, it is worth noting that women were cited as perpetrators of bullying by 27.8% of respondents who self-reported as bullied, but it was not analysed as to whether there was an association between the gender of the victim and the gender of the perpetrator. These issues would benefit from further research but suggest that there is the need for greater education and change in this area.

The examples above serve to extend our understanding of the wide and varied range of issues associated with workplace bullying. It is not possible to do these, or the other issues raised by members, justice in such a short article.

Overall, however, the findings of this research into workplace bullying confirm findings in other research that identifies bullying and harassment as a major problem in the health sector. The emails and comments received leave no doubt bullying can have devastating effects for all those involved. The ASMS is committed to playing our part in preventing this behaviour and assisting with limiting negative consequences when bullying occurs.

The ASMS continues to support all members involved, as well as encouraging anti-bullying programmes and restorative practices as an approach to dealing with the problem. An updated ASMS Bullying Standpoint is being published to support members in also doing 'their bit'. All members and their employers alike have a responsibility to speak out against bullying and work towards positive change.

ERRATUM IN HEALTH DIALOGUE:

Figure 5 (p17), Figure 8 (p20) and Figure 9 (p21) in the enclosed *Health Dialogue* have their legends accidentally omitted. For all three graphs, the legend should read as follows:

Red: Yes, weekly or daily
Yellow: Yes, to some degree
Green: Never

It is an employer's responsibility to ensure staff do not have to face abuse and aggressive behaviours from anyone they interact with at work.

DR HEIN STANDER

PRESIDENT'S ADDRESS – ASMS ANNUAL CONFERENCE NOV 2017

DR HEIN STANDER | ASMS NATIONAL PRESIDENT

One of the first cold winter nights of 2017. I am sitting in front of our fireplace, relaxing with a glass of red wine when I suddenly became aware of the silence of our now empty nest. A weird thought came to me; If I was an insect I would be fast approaching the end of my life cycle. I distinctly recall being very grateful that I am human.

A few weeks later I was looking through the folders of a memory stick that belonged to my Dad. He used it to save the documents he was actively working on. My eye caught a folder I had not noticed before named "Flitse" (Afrikaans), translated: "Flashes". The folder contained a single Word document. As the name would suggest, it contains "flashes" of thoughts, ideas, philosophical moments and unfinished poems.

One poem was of particular interest to me:

> *Ek wat geen god wil hê wil soms tog ook net dankie sê.*

A direct translation:

> *I, who don't want a god occasionally also want to say thank you.*

I found it strange that my Dad so strongly linked gratitude with religion. He was an atheist, albeit with a very good knowledge of the Bible and Buddhism.

It stimulated me to explore the topic of gratitude. We are grateful for things we receive. Perhaps a gift, a favour, an opportunity. There should be no strings attached, no expectation that you need to repay or reciprocate. We could be grateful for things we often take for granted like clean running water from our taps.

Let me start at the beginning, in fact, your or my beginning. We can all be grateful for the fact that we were born in the first place. The chances of you being born as a unique individual have been calculated by Dr Ali Binazir. He is a graduate of Harvard College and Cambridge University, a trained physician and behavioural change therapist. He came to the conclusion that the probability of you being born is one in 10 to the power of 2,685,000. He puts it into perspective; it is the same as 2.5 million people coming together to each roll a trillion-sided dice and each roll coming up with the exact same number (**https://www.huffingtonpost.com/dr-ali-binazir/probability-being-born_b_877853.html**).

The more I read about gratitude, the more I realised that there is a big difference between occasionally being grateful and living a grateful life. Living a grateful life can have a significant, positive impact on our health, well-being and happiness - but it does take some effort. You have to pay attention and develop an appreciation for everyday life and events. I decided to try and introduce this into my own life. To try and make it easier to implement I decided to memorise it as 3 Ps: Pause, Perceive, Proceed.

Pause: you have to stop what you are doing, take time out and clear your thoughts for a moment.

Perceive: Make use of your senses and take note of what has just happened or is happening. There are so many gifts, luxuries and opportunities we experience and are presented with every day.

Proceed: Most of the time you don't have to or need to do anything, acknowledge the gift, be grateful and appreciate it for what it is. Occasionally you will be gifted an opportunity that will require a decision. What are you going to do with the opportunity that you have been gifted? As doctors we are absolutely spoilt with opportunities to help people, to make a difference, to improve their lives but how often do we pause, perceive and take note of the opportunity and actually be grateful for it? (**https://www.ted.com/talks/david_steindl_rast_want_to_be_happy_be_grateful**).

I found this very enriching, and it gave me a new perspective on life. But then I came to realise something horrible. There were several instances where I caught myself being grateful for things that did not happen to me. Something bad happens to another person and I caught myself thinking: "thank god, that could so easily have been me". It struck me that that is one of the most selfish things a person can ever think or say. It implies that it is okay if it happens to some else, as long as it is not me. Awful things have happened and keep happening to colleagues of mine, colleagues of us. Enough is enough, I thought. I have to do something about it. We have to do something about it. If only for selfish reasons; if it can happen to our colleagues, then given enough time, chances are it will happen to us as well.

Dr Andrew Bryant's wife opened up about his death in an email to friends, family and colleagues. The email went viral. Andrew was a gastroenterologist for 20 years, doing private and public work. He had no history of depression but over a period of time, she noticed he was more anxious about his patient administration, about some of his patients and about his own competence. His already bad sleep pattern deteriorated further. He had an awful week of on-call being called every night, sometimes three or four times, but he continued to do his daytime endoscopy lists and see his patients. He missed his son's birthday that week and every other dinner. On the Tuesday night, he was upset and teary after a patient has died. He was always upset when any of his patients died, but his level of distress, in this case, was unusual. On Thursday morning he took his own life in his office. She points out that no one saw it coming. He was a doctor. He was surrounded by health professionals every day. Both his parents were psychiatrists. Two of his brothers are doctors. His sister is a psychiatric nurse. None of them saw it coming (**http://www.couriermail.com.au/news/queensland/wife-of-brisbane-doctor-who-died-in-his-office-issues-note-explaining-his-death-to-help-others/news-story/c2511937adcba50f9906e1bde972c346**).

In the October 2017 issue of the *New Zealand Doctor* magazine, Cliff Taylor recounts the challenge and the shame of burnout for two general practitioners, Drs Lucy O'Hagan and Jo Scott-Jones.

"The burnout was bad," Dr Lucy O'Hagan says. "But the shame was crippling. Shame is worse than failure." She hit the wall, broke down, went over the edge. "It felt like a head injury," she says. "I should have stopped two years before."

Dr Jo Scott-Jones recalls that all the signs were there. He started to show symptoms of depression. He was quite teary, crying on the way home from work, not infrequently. He had transient self-destructive thoughts – "If I drifted the car over to the other way, nobody would mind" – although he says he was not actively suicidal. He recounts: "I've been asking people subsequently, and everybody has a burnout story. Some are not open to sharing it, but most of us have been there."

Both GPs have called for changes in the "culture of medicine" which prevents doctors seeking help.

Ron Paterson and John Adams published an article in the April 2011 *New Zealand Medical Journal* titled 'Professional Burnout: a regulatory perspective.' They discuss the issues we now know too well but also highlight the additional stress a doctor experiences from mistakes and complaints. Albert Wu has called the doctor who makes a mistake "the second victim" of medical error (**https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2011/vol-124-no-1333/view-paterson**).

Six years ago, they suggested changes in three areas to prevent and alleviate burnout:

- *Culture change:* There needs to be a culture change within the health professions so that practitioners feel able to seek help.
- *Support services:* Employers and colleges need to do a much better job of supporting doctors facing stress of any sort.
- *Responsive regulators:* Regulators need to handle complaints and inquiries promptly and sensitively.

Has any progress been made since then?

Research done by Dr Charlotte Chambers of the ASMS reveals that presenteeism was reported by 88% of respondents over a 24-month period. This was followed by the revelation that 50.1% of hospital specialists reported symptoms of burnout. Nearly half (42.1%) said this was due to their work.

During the course of this year's Annual Conference, you are going to hear about the prevalence and impact of bullying and bad behaviour in the workplace. Our ongoing survey of clinical leaders on Senior Medical Officer staffing needs highlights significant understaffing at SMO level across those DHBs surveyed to date. Does this paint a picture of a safe work environment that will help you to stay healthy and keep your patients safe? A supportive work environment that encourages you to seek help?

Presenteeism, bullying, burnout - these are *not* diagnoses. They are symptoms, symptoms of a health care system that has significant problems. It is taking its toll on the workforce and, in turn, adversely affects patient care.

We have gone well beyond the "keep calm and carry on" point. The cost of doing nothing is huge. The scene at the bottom of the cliff is awful. Doctors whose careers and family lives have been destroyed. Doctors in rehabilitation. Doctors needing mental health intervention and, sadly, headstones marking the graves of colleagues.

The situation at the top of the cliff is complex. In a 2011 publication in Archives of Surgery entitled "Special report: suicidal ideation among American surgeons", out of 7905 participating surgeons, 501 (6.3%) reported suicidal ideation during the previous 12 months. Only 130 surgeons (26.0%) with recent suicidal ideation had sought psychiatric or psychologic help, while 301 (60.1%) were reluctant to seek help (**https://jamanetwork.com/journals/jamasurgery/fullarticle/406577**).

What figures are available for SMOs seeking help in New Zealand? Dr Tim Cookson of the MPS was kind enough to share the number of SMOs that sought counselling from the MPS/MAS counselling service over the past 5 years.

YEAR	CONSULTANT
2012	35
2013	36
2014	27
2015	47
2016	46
2017	48

Tim Cookson and Wayne Cunningham published an article in the NZMJ in August 2009 outlining the experience of doctors using their funded counselling service. They conclude: The MPS/MAS-funded counselling service is effective and well received, but there is insufficient awareness of its availability (**http://www.nzma.org.nz/_data/assets/pdf_file/0005/17789/Vol-122-No-1300-07-August-2009.pdf**).

The reasons for not seeking help are multiple and complex, but well known. A major obstacle in seeking help is the culture of shame and a fear we will end up being reported to the Medical Council. We somehow believe we have failed if we seek help.

Let's move away from the cliff's edge and consider some of the factors that might influence the current epidemic.

Change in culture:

It is clear that we need a cultural shift. I agree with Ron Paterson, John Adams and more recently, Dr Sam Hazeldine. Dr Hazeldine's successful petition led to an addition to the Declaration of Geneva's Physician's pledge. I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard. Will this in itself solve the problem? No, but it is a step in the right direction. I strongly feel we also have a responsibility for the health of our colleagues. If we don't look out for each other, who will?

The work environment:

The health care system in New Zealand is under tremendous pressure. We are caught up in a vicious cycle and our employer (including the Ministry of Health and the previous Minister of Health) somehow do not grasp this. The result of a vicious cycle is that things get worse and worse over time. Compare that with a virtuous cycle which delivers desirable outcomes and it just keeps getting better. Cycles are complex chains of events with no tendency toward equilibrium. They have feedback loops in which each iteration of the cycle reinforces the previous one. It will continue until an external factor intervenes and breaks the cycle.

You have the right to work in a healthy and safe environment. Our employers, District Health Boards, are responsible for managing their work-related health and safety risks. Are they fulfilling their legal obligation? Motivating health care workers with slogans like the recently retracted: "Don't stop when you're tired. Stop when you are done," is highly insensitive. DHBs should be held accountable for the current damaging work environment that exists and the lack of progress in addressing it.

Investigation of clinical practice:

"Employers and colleges need to do a much better job of supporting doctors facing stress of any sort, including from the impact of mistakes and complaints." (Ron Paterson and John Adams).

From the MECA: The employer shall ensure the investigation is undertaken as sensitively as reasonably possible with respect to the employee and encourage the employee to seek appropriate professional and other support throughout the process.

This is a highly stressful situation for any clinician to be in. There are enough research and publications out there to support this fact. In reality, what encouragement is actually given and/or offered? Is there ongoing follow up and monitoring of the clinician to be sure that he or she is coping and staying safe and did in fact seek help? The literature is clear that there are complex factors at play here and an "are you okay?" question is simply not good enough.

Referral to Medical Council:

A referral to the Medical Council or Health and Disability Commissioner is one of the most stressful events in any doctor's life. We know this. The Medical Council does have a Health Committee but its primary objective is to protect the public's health and safety and then address the doctor's health afterwards. The MCNZ seems not to have any obligation to ensure the safety of the doctor or take into consideration whether the doctor is "fit to stand trial". It will, however, decide whether the doctor is fit to practise or not. After much research, I "discovered" the existence of the Doctor's Health Advisory Service which is partly funded by the MCNZ. Do not spend your time looking for a DHAS website. There isn't one (**https://www.mcnz.org.nz/assets/News-and-Publications/Booklets/doctors-health.pdf**).

SOLUTIONS

Culture change:

Unus pro omnibus, omnes pro uno. "One for all, all for one". This term was first recorded in a meeting in 1618 attended by leaders of the Bohemian, Catholic and Protestant communities. A representative of the Protestants read a letter affirming, "....., we would stand firm, with all for one and one for all... nor would we be subservient, but rather we would loyally help and protect each other to the utmost, against all difficulties." (Helfferich, Tryntje (2009). **The Thirty Years War: A Documentary History**. Indianapolis: Hackett Publishing Company. p. 16.)

We are not insects. We are indeed human with all its advantages and disadvantages. To err is human. We practise the first rule of medicine 'First do no harm', yet when it comes to dealing with our colleagues, we have a very narrow bandwidth of what we tolerate both culturally and professionally. We need to replace bullying with random acts of recognition and supporting each other. Support also includes providing advice, sensitively given, where a colleague might need further cultural proficiency or provisional development.

There is an old African proverb: 'The one who walks alone by the river gets eaten.'

Establish a "Pastoral care" department in each DHB:

Pastoral care is an ancient model of emotional and spiritual support. We know doctors are very reluctant to seek help or report bullying. We know half of us have reported symptoms of burnout. We know receiving a complaint, a referral to HDC or the Medical Council is extremely stressful. Do we sit back and wait for a doctor to seek help? Do we soothe our conscience by fulfilling our duty and inform a doctor in distress that they should seek help? Or do we proactively provide help and walk alongside them, supporting him or her through a very difficult time?

Medical Council of New Zealand:

I want to challenge the Medical Council of New Zealand to review its current processes in dealing with doctors and practitioners that have been referred, for whatever reason, to firstly establish that the doctor is "fit to stand trial" and ascertain that support has been put into place to keep the doctor safe during the process. Is it acceptable to hide behind the "we are responsible for protecting the health and safety of the public"? My colleagues and friends are also members of the public and also have mental health needs and a right to professional help to protect against self-harm and destruction while the Council's processes run its course.

The work environment:

We cannot allow burnout and bullying to continue. DHBs can no longer stand by idly and not address the current working conditions so conducive to burnout and bullying. They have a legal responsibility to provide us with a safe work environment. We have to intervene and break the vicious cycle. I am fully aware that the new Government has inherited a public health service that has been under-resourced for a number of years. I implore the new Minister of Health, the Director General of Health and Treasury not to distance themselves from this but to recognise their responsibility and be part of the solution.

You cannot harm or attack doctors, or any member of the health care team, without it impacting on patient safety and care. I am sure the Health Quality & Safety Commission is very aware of this fact and will be supportive of initiatives to improve the safety of our patients.

You will have an opportunity tomorrow to explore the topic of bullying further as well discussing the above proposed solutions. I would love to hear your thoughts and have your input.

I have endeavoured to compile a list of counselling services available to us.

PLEASE SEEK HELP. *There is no shame in it.*

https://www.nzma.org.nz/about-nzma/nzma-structure-and-representatives/councils/dit-council/are-you-ok/get-urgent-help!/does-someone-you-know-need-help-urgently

http://www.medicalprotection.org/newzealand/help-advice/counselling-service

https://www.eapservices.co.nz/services/

http://www.cmc.org.nz/media/42323/2016_01_15_doctors_health_services_content_for_website.pdf

The Doctors' Health Advisory Service (DHAS) helps doctors and their families with personal and health problems. It can be contacted on 0800 471-2654. DHAS is partly funded by the Council.

If you are aware of any other services available, please let me know for inclusion on the ASMS website (**www.asms.nz**).

DELEGATES AT THE 2017 ASMS ANNUAL CONFERENCE. HEALTH MINISTER DR DAVID CLARK IS NEXT TO ASMS NATIONAL PRESIDENT DR HEIN STANDER (CENTRE, FRONT)

WELL-BEING THE FOCUS OF ASMS ANNUAL CONFERENCE

The well-being of senior doctors and dentists working in New Zealand's public health system was the theme of this year's ASMS Annual Conference.

The Conference was held at Te Papa in Wellington on 23/24 November, and was attended by more than 130 people, including international guests, observers and national office staff.

As always, it was an opportunity to hear about the latest insights, initiatives and research relevant to the work of SMOs. There were also opportunities to network with colleagues from around the country, including the pre-Conference function, Conference dinner, and a breakfast meeting for ASMS' women members.

For the first time, Conference presentations open to the media were live-streamed by ASMS. Videos of these presentations will be posted soon on the ASMS website (**www.asms.nz**).

ASMS National President Dr Hein Stander delivered a rousing address on the first day, focusing on SMO well-being. A full copy of his address is in this issue of The Specialist.

Other highlights also reported elsewhere in this issue of the magazine include the first Conference address by new Health Minister Dr David Clark, and the release of ASMS survey findings on bullying in the New Zealand senior medical workforce by ASMS Principal Analyst Dr Charlotte Chambers.

Other presentations included:

- ASMS National Secretary Jeff Brown and New Zealand Medical Students Association wellbeing officer Emma Wilson talked about moves to develop a mentoring programme for SMOs and medical students.
- Greetings from Kieran Bunn of the New Zealand Medical Students Association and Marika De Vecchis from the Australian Salaried Medical Officers Federation.
- Canterbury DHB forensic psychiatrist Dr Erik Monasterio talked about his personal experience of stress.
- Dr Victoria Atkinson, Chief Medical Officer and cardiothoracic surgeon at St Vincent's Health Australia, on initiatives to change culture to address negative behaviours and improve safety.
- Simon Kayll, Chief Executive of the Medical Protection Society, on the work of MPS and his observations.
- Dr Harley Aish and Martin Stokes, Chair and Chief Executive respectively of the Medical Assurance Society, on ethical investment and support for 'good causes'.

The Conference also considered formal business, which included approving the minutes of the 2016 Annual Conference, the 2017 Annual Report, the financial report, the national officers' honoraria, appointment of auditors, and discussion of constitutional issues and proposed amendments.

DR ERIK MONASTERIO

DR VICTORIA ATKINSON

MARTIN STOKES

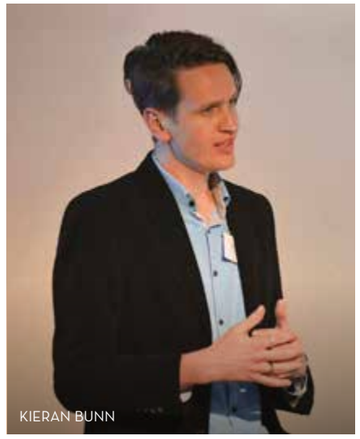
DR HARLEY AISH

DR HEIN STANDER

IAN POWELL

SIMON KAYLL

MARIA DE VECCHIS



KIERAN BUNN

DR JEFF BROWN AND EMMA WILSON

WOMEN'S NETWORK BREAKFAST

ANGELA BELICH AND DR JULIET RUMBALL-SMITH

WOMEN'S NETWORK BREAKFAST

At the 2016 ASMS Annual Conference, women members expressed interest in establishing a network for women doctors, whatever their stage of medical career, and for ongoing connections among women specialists within ASMS.

As a result, ASMS set up the 'Women in Medicine' Facebook group for women doctors and medical students, and this has proved highly successful in the past year.

This year's ASMS Annual Conference provided another opportunity for women members to meet and discuss issues of shared interest. About 40 people included a breakfast on the second morning of the conference, and Juliet Rumball-Smith spoke about the work and purpose of the Wāhine Connect network she has set up (**https://www.wahineconnect.nz/**).

There was a call for members to champion the network as it develops further – if you would like to be involved in this, please contact ASMS Industrial Officer Sarah Dalton at **sd@asms.nz**.

VITAL STATISTICS

In 2016, of 31 selected specialties (excluding internal medicine 'sub-specialties'), there were fewer specialist trainees than current specialists aged 55 and over in all but three specialties – emergency medicine, oral and maxillofacial surgery, and paediatrics.

When counted as full-time equivalents, there were fewer specialist trainees than current specialists aged 55 and over in all but four specialties – emergency medicine, paediatrics, maxillofacial surgery and rural hospital medicine.

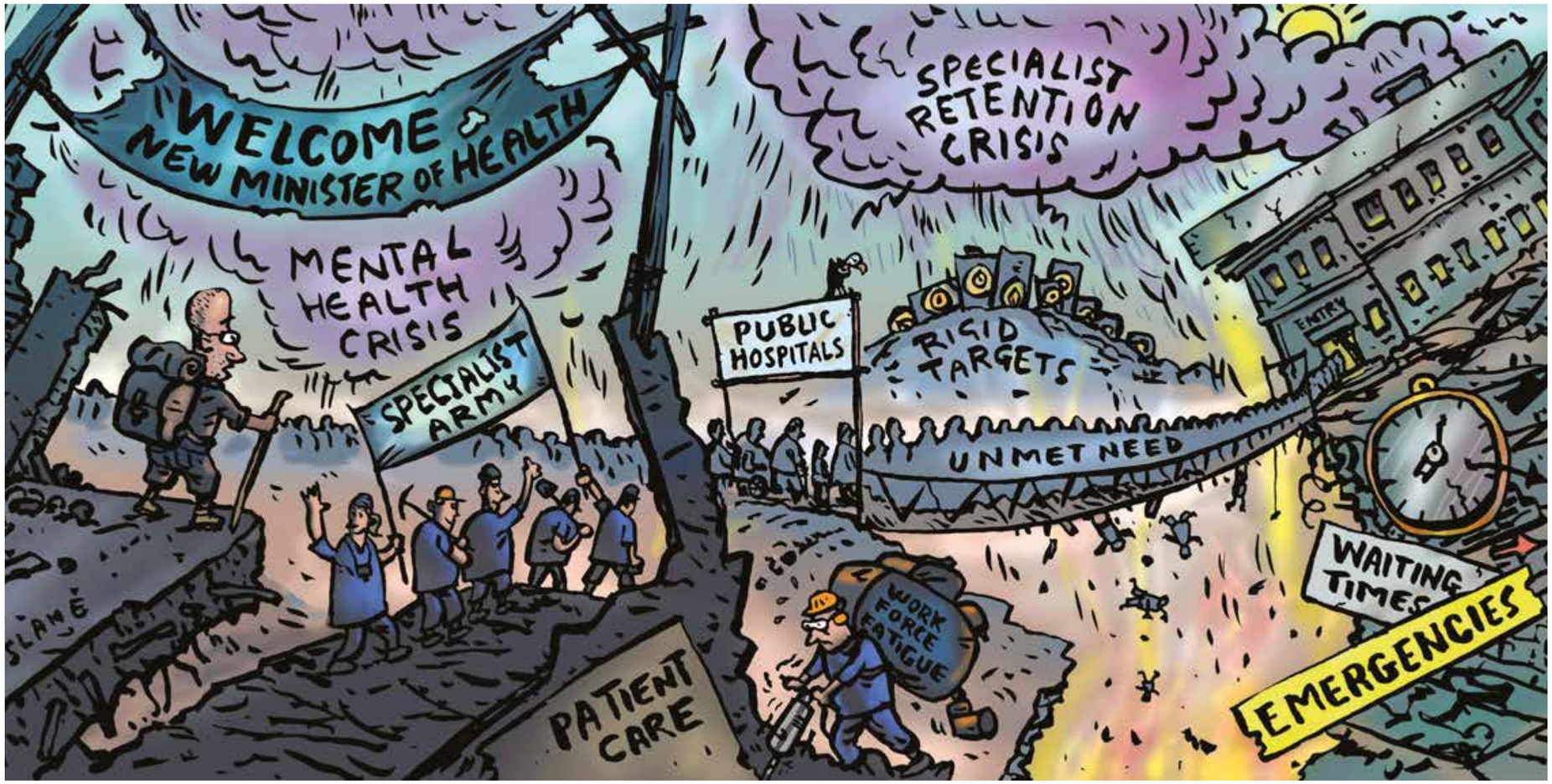
Source: Ministry of Health workforce data. Includes doctors practising in the public and private sectors as at 30 June 2016 (specialists) and 31 March 2016 (trainees).

SEASON'S GREETINGS

The ASMS National Executive and national office staff wish you all a safe and happy holiday season.

The national office will close early on the afternoon of Friday 22 December 2017 and reopen on Wednesday 3 January 2018.

If you have an urgent query over this period, please email support@asms.nz and someone will get back to you.



DR DAVID CLARK

NEW HEALTH MINISTER HITS THE RIGHT NOTES AT ASMS ANNUAL CONFERENCE

The first address to the ASMS Annual Conference by the new Health Minister, Dr David Clark, was one of the most anticipated items on the Conference agenda – and the Minister didn't disappoint.

Dr Clark praised the work of ASMS members in helping to hold together the public health system during a sustained period of neglect, and acknowledged the ongoing pressures on the senior medical workforce.

He also acknowledged the mentoring and knowledge of his Labour predecessor in the health portfolio, Annette King. He talked about his family background and how he became interested in politics, and in working to change inequalities, and he gave a clear commitment to properly resourcing and funding public health services.

"People shouldn't have to sell their houses to get the surgery they need," he told Conference delegates.

His address was well-received by senior doctors and dentists, and the Minister stayed afterwards for a brief question-and-answer session, a group photograph and morning tea with delegates.

ASMS commented in a media statement that the Minister's speech sent a strong signal that the systemic neglect of the past was going to change (**https://www.asms.org.nz/news/asms-news/2017/11/23/new-health-minister-off-good-start-speech-senior-doctors-conference/**).

DR DAVID CLARK AT MORNING TEA, WITH CONFERENCE DELEGATES

The ability of the health sector to deliver effective and high-quality services is dependent on addressing the social, cultural and economic context in which ill health and disability arise.

WHAT YOU MIGHT HAVE WANTED TO KNOW ABOUT THE BIM BUT HAVE BEEN TOO DISINTERESTED TO FIND OUT

IAN POWELL | ASMS EXECUTIVE DIRECTOR

What is a BIM, one might ask, or opt never to ask? Quite simply it means 'Briefing to Incoming Minister'. It is standard practice for government departments to provide incoming (including re-elected) governments a policy briefing. These briefings go to specific cabinet ministers. The Health Ministry, for example, forwards its BIM to each the incoming Minister of Health. Treasury is prone to cover almost everything under a fading neoliberal sun so its BIM to the incoming Finance Minister is very broad in its coverage, including health and education policy.

Non-government organisations including unions, professional associations, industry and business groups, and not-for-profit organisations for some time now picked up on this and submitted their own BIM. Many of these BIMs are far too long and dense (the odd one unreadable) and as a result, not read.

WASTE OF A MUG?

ASMS has got in on the act. After previously forwarding longer documents, following the 2014 election, we went to the opposite extreme by personally presenting then new Health Minister Jonathan Coleman a one-sheet rolled scroll sitting in an ASMS branded mug. Such was the success of this novel approach that our National President Hein Stander has wittily quipped on more than one occasion: "can we have our mug back please?"

In the case of the latest new incoming Health Minister David Clark, ASMS took a middle ground in which we submitted a five-page BIM but only three were text highlighting seven main issues. The other two comprised graphs, links and references. What is even better is that Dr Clark has read it and responded positively, as witnessed by his well delivered and well received speech at the ASMS Annual Conference on 23 November.

HIGH RESONANCE ISSUES

Two of our issues resonate strongly with the policies of the new coalition Government. The first, halting privatisation, is easy for Dr Clark to address. It is already explicit that the controversial and high risk 'private public partnerships' imposed by the previous Government in Westport, Christchurch and Dunedin will not proceed.

A litmus test will be the move by Taranaki DHB to privatise its hospital laboratory. This is somewhat left field for Dr Clark. But again, it is straightforward to deal with. No contractual obligations have been entered. Further Ministerial approval is required for private organisations to use public hospital facilities. All the new Health Minister needs to do is advise forthwith that approval will not be given, and all the stress and strain on the workforce is removed.

Investing in population health is ASMS' second high resonance issue. The ability of the health sector to deliver effective and high-quality services is dependent on addressing the social, cultural and economic context in which ill health and disability arise. Health inequality is inextricably linked to wider social issues such as housing and poverty. Reducing the socioeconomic drivers of poverty and ill health must be a high priority for whole-of-government investment and action. Labour-led governments have generally been strong on promoting population health in a way that makes for a close alignment with ASMS priorities.

ASMS staffing surveys of five DHBs have indicated an average SMO staffing shortfall equivalent to 22% of the current staffing allocation.

Funding shortfalls are creating barriers to accessing services which means more New Zealanders than ever are unable to get the health care they need.

THE NEGLECT OF THE SPECIALIST WORKFORCE IN DHBS

Sitting beneath the other five issues in our BIM is the previous Government's neglect of the pressures on the specialist workforce in DHBs and the lack of a direction forward. Long-term shortages were not being addressed. ASMS staffing surveys of five DHBs have indicated an average SMO staffing shortfall equivalent to 22% of the current staffing allocation.

For just over half of specialties, there are fewer registrars training in each area than there are specialists aged 55 or over. There are no registrars training for several specialties.

Three concurrent trends in the specialist workforce have implications for the future workforce capacity and a changing workplace culture:

1. The growing proportion of females in the specialist workforce.
2. Attitudinal changes (generational and gender-related) about work-life balance and workplace culture.
3. The aging of the specialist workforce.

As the younger generation of doctors and dentists, including a higher proportion of females than previously, moves into the DHB specialist workforce, coinciding with a potentially significant proportion of retirements of the 'old guard', desire among our members for real cultural change (relating to management and colleagues) will likely become increasingly important for work satisfaction, recruitment and retention.

This precarious situation which comprises doctor well-being and the achievement of patient centred care requires rectification, which is the focus of the five remaining main issues in the ASMS BIM.

1. RE-INVESTMENT IN THE PUBLIC HEALTH SYSTEM

The continuing trend of funding cuts to government health expenditure since 2009/10 has accumulated to the point where the new Government will need to find well over $2 billion additional funding for 2018/19 if it wishes to restore the value of funding to 2009/10 levels. These funding shortfalls are creating barriers to accessing services which means more New Zealanders than ever are unable to get the health care they need.

2. INVEST IN THE PUBLIC SPECIALIST WORKFORCE

New Zealand's long-term specialist workforce shortages are negatively affecting workloads, well-being and productivity. Indicators of these shortages include high rates of burnout, working through illness (presenteeism) and intentions to leave the public workforce. These shortages also limit the capacity for improving health service cost-efficiency, clinical effectiveness and accessibility, all of which are causing significant financial waste and are a drain on the economy as a whole.

Greater investment in the health workforce needs to be at the core of a national health workforce strategy, including a comprehensive recruitment and retention plan for the medical workforce as an urgent priority.

3. ADOPT CLINICALLY-LED HEALTH PATHWAYS FOR INTEGRATING COMMUNITY AND HOSPITAL SERVICES

Integrating community and hospital services is critical to improving the efficiency and effectiveness of public health services. The international literature suggests integrating care effectively is possible only if it comes from the bottom up, through specific, clinically led 'micro interventions'.

This was the systemic approach underpinning Canterbury District Health Board's incremental moves to integrate services, which has led to more services being provided in the community and reduced acute admission rates, average length of stay in hospital and readmission rates for both elective and acute surgery. Notably, the initiative did not involve the superficial notion of 'shifting resources from hospital to community'.

4. DEVELOP A CULTURE OF HIGH QUALITY PATIENT CENTRED CARE THROUGH DISTRIBUTED CLINICAL LEADERSHIP

The evidence shows genuine 'patient centred care' is important for meeting increasing health needs and patient expectations. At its core is the healing relationship between clinician and patient and, where appropriate, their family.

Good quality doctor-patient interaction results in better quality and safety of heath care, shorter hospital stays, reduced costs and increased levels of patient and staff satisfaction. Patient centred care requires strong, distributed clinical leadership to accommodate the complexities of a more participative clinical environment which enables high quality clinician-patient interaction.

5. REVAMP HEALTH WORKFORCE NEW ZEALAND

Health Workforce New Zealand was established as a business unit in the Ministry of Health, with a governing board and Executive Chair reporting directly to the Minister of Health.

HWNZ's performance to date has been abysmal, characterised by poor consultation processes (for example, the funding model for vocational training) and inaction on substantive workforce issues, especially the DHB-employed specialist workforce.

The ASMS BIM calls on Dr David Clark to revamp HWNZ. The way it approaches its work needs to fundamentally change so that it genuinely listens to and engages with the health professions to focus on tangible solutions.

HOW NEW ZEALAND'S HEALTH SYSTEM RANKS ALONGSIDE THOSE OF COMPARABLE COUNTRIES

LYNDON KEENE | ASMS DIRECTOR OF POLICY AND RESEARCH

A recent analysis comparing the performance of 11 health systems shows New Zealand's public health system stands up well on measures of administrative efficiency and care processes (ie, quality of care) but falls down the scale on measures of access, equity and health care outcomes.

The largely private health system of the United States (US), despite being by far the most expensive system, was ranked as the worst performer overall, including being ranked last in access, equity, and health care outcomes, and second-to-last (behind France) in administrative efficiency.

The analysis by the US-based Commonwealth Fund is an update of earlier analyses involving Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom (UK), and the US. The data come from a variety of sources, including surveys and information collected by the Organisation for Economic Co-operation and Development (OECD), the European Observatory on Health Systems and Policies, and the World Health Organization (WHO).

ADMINISTRATIVE EFFICIENCY

The top performers in administrative efficiency are Australia, New Zealand and the UK. This includes four measures evaluating barriers to care experienced by patients, such as limited availability of the regular doctor, medical records, or test results. A further three indicators measure patients' and primary care clinicians' reports of time and effort spent dealing with paperwork, as well as disputes related to documentation requirements of insurance plans and government agencies.

CARE PROCESS

Care process encompasses four quality-related subdomains relevant to health care for the general population: preventive care, safe care, coordinated care, and engagement and patient preferences. Again, the UK, Australia, and New Zealand are the top performers. These three countries consistently perform above the 11-country average across all subdomains (except for Australia on coordinated care). Perhaps surprisingly, given the events of recent years, the UK excels in safety. Australia is the top performer in patient engagement. On the other end of the spectrum, again surprisingly, Norway and Sweden's performance is below average on each of the care process subdomains.

On the measure of coordinated care, New Zealand comes out on top, despite the long-established policy of integrating services falling well short of intent, and reflects generally poor reports of coordinated care across the 11 countries.

A specific survey question on whether the "Specialist always or often told patient about treatment choices and involved patient in decisions about care and treatment among adults age 65 and older" received a 63% affirmative response from New Zealand, with the average being 64%. It is one of the few areas where the US performed the best, with an 81% affirmative response.

New Zealand ranked poorly on measures such as access to specialised tests (eg, CTs, MRIs) and waits for treatment after diagnosis.

What is striking is the variation that exists within health systems rather than between them.

ACCESS

New Zealand was ranked seventh on access to services. While New Zealanders in general avoided costs related to insurance payments, affordability issues arose in primary care. And while New Zealand scored relatively well on timeliness of accessing primary health care, New Zealand ranked poorly on measures such as access to specialised tests (eg, CTs, MRIs) and waits for treatment after diagnosis, where we ranked bottom on both counts. New Zealand also scored poorly on waits for first specialist appointments, and waits for elective surgery.

EQUITY

The UK, the Netherlands and Sweden ranked highest on measures of equity with respect to access and the care process. New Zealand was placed eighth. Equity is measured according to the extent of the difference in responses to selected survey questions between those with above-average incomes compared to those on below-average incomes. The bigger the gap, the lower the equity.

New Zealand's below-average score was due in part to cost-of-access issues. Significantly, however, there was a relatively wide gap between low-income and higher-income earners in waiting times for specialist appointments, where the reported 14% difference was the worst among the 11 countries.

HEALTH CARE OUTCOMES

Australia has the best 'health care outcomes' result overall. Sweden and Norway rank second and third, while the UK and the US had the worst results. New Zealand was ranked seventh, with the results showing relatively poor infant mortality rates (more than twice as high as Sweden and Norway's results) and the second-worst result (ahead of the US) on the rate of mortality amenable to health care, where our 87 deaths per 100,000 population was 58% higher than Switzerland's, which recorded the best results.

New Zealand's results in the 2017 report are similar to those in the Commonwealth Fund report published in 2014, but with slight improvements in equity, quality and efficiency measures. Our overall ranking improved from seventh in 2014 to fourth in the latest report.

REACTIONS TO THE REPORT

Health policy commentators, especially in the UK, caution that international comparisons of health systems have limitations, as they depend on which indicators have been included and how different dimensions of performance have been weighted. The Commonwealth Fund's methodology has been criticised for giving too much weight to surveys and processes.

However, it is also recognised that comparative rankings like the Commonwealth Fund's can be useful. They give us a broad indication of how health systems are doing and raise important questions about how and where improvements are needed. As one observer put it, what is striking is the variation that exists within health systems rather than between them.

No consistent pattern emerges to link the mix of funding or provision models with quality or value, although single-payer systems such as the UK's National Health System (NHS) tend to do better on cost and equity than pluralistic insurance.

The NHS made top spot in the overall rankings despite the longest budget squeeze in its 69-year history, serious understaffing, and the disruption caused by a radical restructuring of the service in England in 2013. Yet the UK had the fourth smallest amount of GDP into healthcare among the 11 countries (based on 2014 figures). While the US spent 16.6% of its national income on health, the UK came near the bottom, investing just 9.9%. Only New Zealand (9.4%), Norway (9.3%) and Australia (9%) put in less.

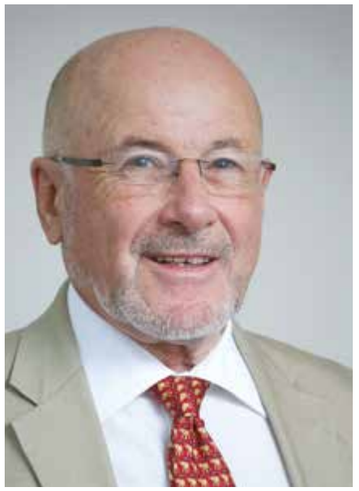
Richard Murray, the director of policy at the London-based King's Fund think tank, told the Guardian newspaper:

"The UK's ranking ... reflects the strong fundamentals of the NHS. Universal access to health services, a founding principle of the NHS, is rightly recognised by the Commonwealth Fund ranking.

"Other international comparisons that are largely based on measuring the health of the population of the country do not always rank the UK as highly. The Commonwealth Fund also recognises these poorer health outcomes [in which the UK ranked 10th], and this is particularly stark given the cuts to public health spending that were announced recently."

HEALTH CARE SYSTEM PERFORMANCE RANKINGS

MEASUREMENT	RANKING										
	1	2	3	4	5	6	7	8	9	10	11
Care Process	UK	AUS	NZ	NETH	US	CAN	SWIZ	GER	FRA	NOR	SWE
Access	NETH	GER	UK	AUS	NOR	SWE	NZ	SWIZ	FRA	CAN	US
Admin. efficiency	AUS	NZ	UK	NOR	SWE	CAN=	GER=	SWIZ	NETH	US	FRA
Equity	UK	NETH	SWE	SWIZ	NOR	GER	AUS	NZ	CAN	FRA	US
Health care outcomes	AUS	SWE	NOR	SWIZ	FRA	NETH	NZ	GER	CAN	UK	US
Overall ranking	**UK**	**AUS**	**NETH**	**NOR=**	**NZ=**	**SWE=**	**SWIZ=**	**GER**	**CAN**	**FRA**	**US**



DR PETER MOODIE

IN DIALOGUE

THE SUSTAINABILITY OF GENERAL PRACTICE AND VLCA

The September issue of The Specialist included an article on the Very Low Cost Access (VLCA) scheme by John Ryall, Assistant National Secretary of E tū and Hutt Union and Community Health Service Board member. In this issue of the magazine, Dr Peter Moodie continues the discussion.

Dr Moodie has been a primary care specialist for over 30 years. He has been a partner and director of the Karori Medical Centre over that time. He also held the role of Medical Director of Pharmac for 14 while still remaining in active practice. In 2015, he chaired the Primary Care Working Group which reported to the Minister of Health on the sustainability of general practice.

In 2015, a Primary Care Working Group (PCWG) was established to report to the Minister of Health about the sustainability of general practice. An essential part of that was to explore ways to achieve equitable funding, particularly for high-need and low-income patients in New Zealand. In addition to looking at funding models in general, the PCWG was specifically asked to evaluate the so-called 'Very Low Cost Access' (VLCA) scheme.

As part of its information gathering, the PCWG ran a series of forums around the country and invited people to fill in a questionnaire, with some 600 primary care providers responding in one form or another.

HOW IS PRIMARY CARE FUNDED IN NEW ZEALAND?

Since 2003 virtually all general practices have used a 'mixed' funding model. Each general practice must identify all patients formally registered with them and this list is submitted to the Ministry of Health on a quarterly basis. Based on these numbers, a fixed 'capitation' (per patient) payment is then made to the practices, which must use this to subsidise patient co-payments. The basic per-patient capitation is the same for all patients, irrespective of social, health or economic circumstances; however an additional capitation payment is made for children under the age of 13 if practices agree to treat them without charge. Practices may also charge a 'co-payment' to patients over the age of 12; this co-payment is regulated and if a practice increases fees above the allowable threshold, the practice is subject to a DHB fee review process.

SO WHAT IS A VLCA PRACTICE?

In 2006, a voluntary scheme was introduced whereby a practice (and it had to be a practice) could access a further capitation top up if it agreed to a fixed patient co-payment (for all patients over 12) of $17.50. Any practice could join the scheme.

The VLCA option was particularly attractive to practices with high numbers of low-income patients; however a number of practices serving modest numbers of low-income patients also joined. By 2009, approximately one third of practices in New Zealand had joined the scheme

In 2009, the then National Government prevented any further practices from joining the VLCA scheme unless they had at least 50% 'high-needs' patients. High needs was defined as patients living in a Deprivation Quintile 5 abode and/or who were of Māori or Pacific descent. It was this variation that has caused concern and was one of the reasons for the PCWG inquiry.

SO WHAT IS THE PROBLEM WITH THE VLCA SCHEME?

The PCWG determined that the current distribution of funds to lower the cost barriers for high-needs and low-income patients was not allocated in a fair manner. The VLCA formula funded practices rather than individuals and was available only to practices that had taken up the scheme, rather than aiming it at high-needs patients in general. The impact of this was that some 45% of low-income (and/or high-needs) patients missed out on low-cost access simply because they were not enrolled (or were not able to enrol) in a VLCA practice. By the same token, patients with higher incomes paid the reduced fee if they enrolled in a VLCA practice.

The 2009 variation to access to the scheme created a further anomaly as the original practices that were not low-income practices were allowed to remain in the scheme. In at least one area, a relatively high-needs practice (35%) that wanted to join in 2012 has been excluded but is finding itself competing with an entrepreneurial practice next door that had joined the scheme before 2012 and was offering significant lower fees under VLCA.

SO WHAT DID THE PCWG RECOMMEND?

That:

- Increased subsidy funding should follow patients, not practices and this should be reflected in the capitation payments.
- Low-income patients should attract lower co-payments and this should be regulated. The PCWG looked at various options and concluded that the Community Services Card and those living in Deprivation Quintile 5 areas were the most appropriate criteria in the first instance.
- It was acknowledged that Māori and Pacific people have higher health needs at an earlier age and this should be reflected in the capitation formula; however ethnicity should not be used to determine eligibility for lower co-payment. It was, however, recommended that performance targets aimed at improving the health of specific population groups should be implemented.
- It was further recommended the so called Care Plus scheme should be expanded to specific high-needs patients, particularly with long term conditions, so they could access lower cost care.
- VLCA practices should be subject to the same rules as other practices. This means that these practices can charge their non-high needs patients more; however the funding formula should be cost neutral for genuinely high-needs practices.

The findings are well documented in the PCWG report along with the proposed solutions. The group set out to provide solutions that were logical and sustainable in the long term for both practices and for patients.

SO WHERE IS THE PROBLEM?

In 2016, at least one critique of the PCWG report was published that had both factual errors and omissions, which seriously confused the Group's recommendations. There were even arithmetic errors (one clinical group was alleged to benefit from the new funding formula by >244,000%, where the correct figure was 7%).

There was also a concern that some middle or high income patients would have to pay more for their health care. Indeed this was true but only if no extra funding was injected into the system. Our recommendation was that at least another $40 million needed to be invested in the primary care budget.

In summary, the PCWG determined that the current system of targeting is unfair to those with high health needs and low incomes, and co-payments for these groups are becoming unaffordable. Unless the anomalies in the funding system are addressed, the problem can only get worse.

The high cost of accessing primary health care is a real issue with 21% of Māori/Pacific peoples stating that they have delayed seeking care because of cost. This needs to be addressed in a nationally consistent manner.

REFERENCE

Primary Care Working Group on General Practice Sustainability. Report to the Minister of Health. General Practice New Zealand: January 2016

The PCWG determined that the current distribution of funds to lower the cost barriers for high-needs and low-income patients was not allocated in a fair manner.

The high cost of accessing primary health care is a real issue with 21% of Māori / Pacific peoples stating that they have delayed seeking care because of cost.

MEMO MUSA

NURSING MATTERS 2017

MEMO MUSA | CHIEF EXECUTIVE, NEW ZEALAND NURSES ORGANISATION

Playing the long game in the health workforce development and health funding arena is a challenge because you know the prize but the progressive steps to get there are many, and sometimes few and far between, so to speak. But there has been progress, and that is great to report as the year ends.

The New Zealand Nurses Organisation (NZNO) has run several campaigns to bring the top issues for nurses to the forefront – namely, health funding, safe staffing, professional development and graduate employment.

The last two years have seen intensification of the call to government for more and better health funding by several organisations in the health sector. In the last year, in particular, this call has been refined to be more than about money – it is also about the growing concern that staff are under too much pressure, and this risks the health of the workforce itself. The repercussions of this are indeed that New Zealanders are not getting the top rate services they need and deserve.

Nurses make up half the health workforce, so they are highly involved in health care and critical to the well-being of New Zealanders. In fact, nurses are everywhere in health. Many years of underfunding has meant that nurses are limited in their ability to work to the depth of their knowledge. One platform the new Labour-led Government campaigned on was its promise to put back the $2 billion missing in Vote Health. NZNO will of course be watching this with sharp interest but are satisfied that many of their promises are in the speech from the throne. Addressing cheaper access to primary health care for children is excellent to see, as this relieves pressure at the hospitals and sets up preventative health care and nurse education for the family sooner. We are interested in the reinstatement of the Mental Health Commission and how this will work to rectify the delivery of primary health care for mental health needs.

IMPACT OF CHRONIC UNDER-FUNDING

However, the fallout from consecutive budget freezes has had an effect on nurses in many ways. Staffing shortages in DHBs have persisted for about 10 years now. The chronic under-funding of this sector and the imposition of targets, which do not necessarily improve health outcomes, has put the system under enormous strain.

The *NZNO Employment Survey 2017* illustrated many areas of concern for nurses in their profession. Clearly, nurses gain professional satisfaction from working to improve the health of those they nurse, and this is why they remain in the profession. This came through clearly in the survey once again, so this is the good news. However, restructures, short staffing, lack of training opportunities and an environment under pressure, which means workplace tensions increase, is taking some of the pleasure out of the job, many reported. Subsequently, many nurses are feeling undervalued.

Over a third of respondents experienced restructuring at work over the last two years. The loss of senior nursing roles was of greatest concern. This was compounded by the fact that so often, to cut costs, nurse managers or nurse leaders were not being replaced and the workload just got passed down. One member surveyed simply resigned as a response to this.

The loss of clinical nurse leadership is a retrograde step. A quarter of those surveyed reported the nursing skill mix was reducing and that more senior nurses were needed.

In addition, having training postponed or cancelled was a frustration. Many senior nurses are saying that professional development is something they want and need and helps them to retain 'interest' in keeping up to date with nursing in their current roles or jobs. Our survey found this lack of attention to training and professional development a prominent cause of dissatisfaction. In this day and age, it is important that nurses continue to train and refresh their knowledge, skill and competencies to keep up with changes in health care, and to better meet the health needs of people who present to them.

"The chronic under-funding of this sector and the imposition of targets, which do not necessarily improve health outcomes, has put the system under enormous strain."

Poor access to training and professional development is also driven by having an inadequate share of around 19 percent of the total national funding for postgraduate training and education programmes. The largest regulated workforce in health receiving the lowest share of such funding is unacceptable, and this has to change in the immediate future.

Another significant issue for nurses at present, aside from the survey, is that senior nurses have said time and time again (this year, in particular) that they now just don't have sufficient time to train up new graduates. Because of short staffing, they just don't get to do the mentoring they used to because they are covering shifts. This issue is particularly acute in mental health. When a senior nurse can't spend time to train up a new entrant, that nurse does not get the help needed in a high-pressure job that requires specialist skill. The fallout of this is that the new graduate leaves the workforce.

Overall, there is a huge under-investment in nursing. This is from graduate placement programmes to training and also pay packages to attract and retain nurses.

LACK OF VISIONARY WORKFORCE PLANNING

Nursing in New Zealand is being let down by the absence of visionary workforce planning, and we do not have robust data to tell us what areas of nursing and how many nurses are needed in the near future. Without a doubt, we need a well-informed approach to plan and manage the supply side to ensure we are educating and training enough nurses to meet future demand and changing models of care. This should include increasing the Māori nursing workforce to match the percentage of the population. The trend is that we will need a lot more nurses. Our population is growing, and by 2050 we are expected to reach 6 million with a huge increase of over-65-year-olds. Adding to this mix is the fact that over a quarter of the nursing workforce is planning to retire within the next 5 to 10 years.

This is one reason why NZNO is working hard to have the Care Capacity and Demand Management programme implemented in all hospitals and why it is on the bargaining table for the DHB Multi-Employer Collective Agreement (MECA) being negotiated now. This is a programme we are using to achieve safe staffing levels or to have the right number of nurses, with the right skill mix and right experience matched to the needs of patients.

Internationally qualified nurses are a vital part of the nursing and wider health workforce. However, many come into positions that are not well supported or well paid in aged care facilities. Our research has found that more should be done to retain nursing recruits from overseas, because to lose them to Australia, for example, is a loss of skill and particular knowledge that is gained here. This problem needs urgent attention.

We have become over-reliant on short-term, high-turnover immigration to fill nursing skill shortages. This, combined with the under-employment of new graduate nurses and lack of investment in nursing career pathways, means the ongoing sustainability of the New Zealand nurse workforce is not actually on target.

It is astounding that not all new graduate nurses are able to find health care employment in New Zealand. While we need internationally qualified nurses, getting the numbers down should lead to greater take up by employers of graduates. Also, better pay at entry level nursing in aged care, for community and primary care, including for Māori and iwi care sectors will also help towards attracting graduates.

On a positive note, a fully funded nurse practitioner programme through to working with employer to secure future employment was a bold move by Health Workforce New Zealand, and results are showing. The increasing number of nurse practitioners and those who can prescribe in their area of competence is pleasing and progressive.

But barriers remain to the best utilisation of their skills, including lack of full employment. Many are working in primary care, rural areas and for Māori and iwi providers. They can be engaged to supervise registered nurses training to become designated registered nurse prescribers. The increase in nurse practitioners and registered nurse prescribers working as members of multi-disciplinary teams is good news

"Nursing is an investment, not a cost, and we will be working through our global alliances to demonstrate the economic impact of nursing, and that to have a sustainable public health system, nursing matters."

for the New Zealand population as this will help to improve access, especially for vulnerable people – those with long-term conditions and who are hard to reach. There is still potential to be realised with these advances in nursing, and NZNO is committed to progressing this with our stakeholders.

On another matter, of note this year are the comments from nurses about the whole picture, so to speak – the social and global situation for nursing and society as a 'well society'.

Aside from the mechanics of nursing and the nursing environment, nurses are increasingly focusing on social equity and health. At our annual conference, Warren Lindberg from the Public Health Association talked about how social inequity and political decisions to fund public health sufficiently or insufficiently lead to social inequity. His presentation gained the greatest applause. This is what nurses are seeing in emergency departments, the face of child poverty statistics and the effect on health, sexual health and also mental health. In the coming year, we will be working to bring some of these social issues that affect health more into focus alongside the direct health funding issues.

NZNO is increasingly stepping up into conversations about global issues like World Health Organization sustainable development goals and universal health coverage and health responses to displaced populations – for example, in areas of conflict. We are campaigning on empowering women by working in the domestic violence legislation space, the equal pay agenda, quality and safety, putting an end to violence in health care settings, assisted dying legislation discussions, synthetic drugs, private–public partnerships, living wage, climate change, the Trans-Pacific Partnership Agreement and more. In addition, we are in the conversation about the effect of globalisation on nursing, including on national nursing associations.

Nursing is a strong and committed workforce but is an aging workforce and under strain from many directions. Our intention is to raise the profile of nursing, build power to influence through alliances and partnerships to show that there is more nursing potential to be released and realised. Finally, nursing is an investment, not a cost, and we will be working through our global alliances to demonstrate the economic impact of nursing, and that to have a sustainable public health system, nursing matters. Access our manifesto *Nursing Matters* to view NZNO's call for the promotion of health, health equity from the start and a sustainable health workforce (**https://www.nzno.org.nz/Portals/0/publications/2017%20NZNO%20Manifesto%20-%20Nursing%20Matters.pdf**).

DR HELEN FRITH, AN ANAESTHETIST AT COUNTIES MANUKAU DHB AND COUNTIES MANUKAU ASMS BRANCH PRESIDENT.

WHAT INSPIRED YOUR CAREER IN MEDICINE?

I wasn't really thinking of doing medicine when I was 17, but I applied and got in to the Auckland Medical School, which was only four years old, on the advice of another medical student. The first year was hard, because I had not done science subjects at school, so I had to catch up. Over the following six years, I came to love it.

WHAT DO YOU LOVE ABOUT YOUR JOB?

As an anaesthetist, I am able to interact with patients and their families, albeit briefly, then take care of a person through one of their most frightening life experiences. I still really enjoy seeing the look of relief in their face when it's over.

I also enjoy the technical aspects of my job, the real-time application of altering physiology and particularly the interactions in the operating room environment with all other members of the team. There is often a lot of stress on a day-to-day basis, especially with trauma and seriously unwell patients, and having a good team relationship helps deal with the stress.

I guess I go to work for the people - both patients and co-workers.

WHAT ARE SOME OF THE MOST CHALLENGING ASPECTS OF PRACTISING MEDICINE?

There are personal and professional challenges in practising medicine. It's often difficult to leave work problems at work and I often think about patients, make plans for the management of a difficult patient and do work emails at home. Work-life balance can be difficult, particularly for parents of young children who are also trying to work and establish their careers at the same time.

The professional challenges involve maintaining competence and confidence, and working in a resource-limited environment. I see many SMOs now in a state of learned helplessness, being able to see how patient care could be improved but not wanting to develop ideas in the face of "there is no money".

WHY DID YOU DECIDE TO BECOME ACTIVELY INVOLVED WITH ASMS?

While I was the clinical head of the anaesthetic department at Middlemore for six years, I attended most of the JCC meetings, because it was important for me to gain knowledge about the wider hospital, and indeed, national medico-political scene. The role of Branch President became available as I was finishing as head of department, so I decided to become more actively involved.

WHAT HAVE YOU GAINED OR LEARNT FROM YOUR ASMS INVOLVEMENT?

I've learned that, as SMOs, we don't work as individuals. All of our medical training is based around the individual doctor-patient relationship, which is fundamentally what we do every day. We treat patients. However, we can't do this effectively without the big "health machine" behind us.

It is also becoming increasingly clear that senior doctors often neglect their own well-being and are not particularly good advocates for themselves.

ASMS is strongly involved in these areas of SMO advocacy, both with health and well-being and the difficult, but very important, negotiation of our MECA.

I guess I go to work for the people - both patients and co-workers.

HISTORIC MOMENTS

EACH ISSUE OF *THE SPECIALIST* WILL FEATURE A PHOTOGRAPH OR DOCUMENT FROM THE ASMS ARCHIVES. YOU CAN FIND MORE SLICES OF HISTORY ON THE ASMS WEBSITE (**WWW.ASMS.NZ**) UNDER 'ABOUT US'.

Editorial

Trouble in the Hospital Specialist Service

The hospital specialist service is maintained under increasing duress. In New Zealand, as elsewhere, specialists both part- and whole-time play an essential part in the hospitals; without them the complex mechanism of modern patient care would be unworkable, and hospitals must cease to function. Yet specialists as a group are today discouraged as never before. They are unhappy about their present working conditions and pessimistic about the chances of improving them. Especially, they are worried about their relations with the Health Department which holds absolute powers over the specialist service, yet which to many appears unaware of the needs of modern hospital medicine, indifferent to efforts to improve standards, and above all unapproachable to its own agents. The result of these doubts and frustrations can already be seen in continued specialist losses overseas and into non-hospital practice, and in failure to fill advertised specialist posts. The future is forecast in restrained language in the recent official Report of the Special Committee on the Availability and Distribution of Medical Practitioners (the A. & D. Committee):

> "If no radical change takes place, the outlook for specialist practice is not encouraging. Time can only bring an exaggeration of the present unsatisfactory position regarding service in public hospitals, the economic difficulties of many specialists, the shortage of specialists in some fields . . . and the problems of those who desire to practise as pure consultants."

Many of the problems facing specialists (or consultants) are well expressed in the A. & D. Report:

> "To become a consultant in any field of medicine demands a long and arduous training, and at very considerable expense. Once established the consultant must keep himself up to date in his specialty. It is not sufficient for him to have knowledge of new developments in the technique of diagnosis and treatment, he must also gain experience in applying them himself. He needs time for reading, for research, and for preparing contributions to scientific meetings. He should assist in the postgraduate training of other doctors. He must be able to go abroad from time to time in order to make contact with those in the forefront of his specialty in other countries."

Let us see how these needs are catered for in New Zealand.

Financial Rewards.—The long and expensive training of specialists, much of it still overseas, the consequent delay of ten or more years in their attaining full professional earning power, and their continuing need to remain up-to-date, make necessary a relatively high rate of remuneration as soon as full specialist status is achieved. At this point in his career, a specialist should be assured of adequate prospects of advancement. Yet the Government Statistician's Reports on Incomes show that specialists' earnings compare unfavourably with those of other groups in the medical profession, and advancement in the hospital service is unpredictable. The position of part-time specialists is particularly difficult. It can hardly be denied that hospital specialists, as a group, are the economically depressed class of New Zealand medicine. If to the overall inadequacy of the salary scales is added the frustration of a personal grading system which imposes successive and arbitrary bars to promotion and, as shown in these columns by Dr D. T. Stewart, makes it impossible for many applicants for specialist positions to forecast their incomes before they are appointed; if it is further recalled that both Australia and England, to take only two examples of other countries, offer very much higher incomes to specialists while living costs are comparable to those in New Zealand, then it is not surprising to learn, as emerged from a recent survey, that at least one in every four full-time specialists left the hospital service in the past five years, and that as many as 70 per cent of those remaining have considered or are considering whether to follow their late colleagues' example. Nor is it likely that present conditions will attract back to this country those of our best young doctors who have gone overseas to complete their specialist training.

Working Conditions.—The New Zealand specialist tends to be overworked as well as underpaid. For years, all classes of hospital work have been expanding much more rapidly than the medical staff attempting to deal with them. The Annual Report of the Health Department for 1960 shows for instance that in-patients in New Zealand hospitals increased by 5% and out-patient attendances by 2%. There were 8% more diagnostic X-rays taken and 14% more laboratory tests done. In the same year the number of general physicians in public hospitals rose by 1.7%, of general surgeons by 2%,

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of radiologists by 2.2% and of pathologists by 3% (all whole-time plus part-time converted to whole-time equivalents). The chronic shortage of junior medical staff forces specialists to do much of the work of those in training as well as their own. It is well recognised that many part-time specialists spend far more time doing hospital work than that for which they are paid; no less is true of whole-time specialists. Where, in this hurly-burly, is there time for reading, for research, and for those other activities which the A. & D. Report, in common with informed opinion the world over, regards as essential in the lives of specialists? Where, for that matter, is there any sign that those in control of the service appreciate these needs?

Research, under the present regime, is sorely restricted in the hospitals, because the Hospitals' Act is interpreted as not empowering Boards to spend any money on *medical* research, although they may contribute annually to the funds of the Research Institute of Launderers, Dry Cleaners and Dyers of New Zealand.

Specialists, to keep up with progress in their subjects, must buy books and instruments, borrow from libraries, join scientific societies and travel to conferences. The costs rise proportionately to the specialist's activity in his field, and proportionately also the specialist is penalised for his enthusiasm because support is inadequate.

Provision for overseas study leave is grossly inadequate in a country whose geographic isolation entails a constant risk of professional men becoming cut off from the main stream of international progress.

Clearly there is a crying need for reforms in working conditions which an increasing proportion of hospital specialists are finding intolerable. Salary scales must be made competitive, gradings must be rationalised and terms of employment made more liberal. If a crisis is to be avoided in the specialist service, the process of reform must begin now. The momentous question—and this is by far the most serious aspect of the present dilemma—is how, and by whom the reforms are to be initiated and carried out. There is no mechanism by which specialists as a body can officially approach their employers and negotiate about their working conditions. Salaries and terms of employment are laid down by Regulation. Specialists, through the British Medical Association, may make representations to a Salaries Advisory Committee. This meets at irregular intervals, deliberates in secret, and makes secret recommendations to the Minister. The Minister eventually comes to decisions for which no reasons are given. The whole process is slow and dilatory, as much as a year having sometimes gone by between the submissions and the Minister's final decision. Specialists find themselves in a supplicant attitude with few direct means of influencing those policies which will inevitably become of vital importance to their well-being.

Although there may be historic reasons for its creation, it is difficult to see how such an archaic system of unilateral dictation has survived in a country which prides itself on its advanced industrial and social relationships. Part of the fault undoubtedly lay with the specialists themselves who until recently, though profoundly dissatisfied with their lot, were unable and indeed often unwilling to analyse the reasons for their difficulties or to propose agreed alternatives to an obnoxious system. Part, too, lay with the profession as a whole. There has for too long been a failure to realise that its different branches have separate and distinctive problems which demand particular solutions; but also that these branches are complementary and interdependent, and hence that all will suffer if one group or another is dissatisfied. Lack of clear thinking on these matters has at times produced ambiguous and uncertain policies. The present Minister of Health himself has more than once deplored the fact that doctors cannot speak plainly and with one voice.

Perhaps the only hopeful sign in a clouded situation is the formation, during the past year, of a strong Central Specialists Committee of the Association in which, with the encouragement of their general practitioner colleagues, hospital and other specialists have at last become united. Simultaneously the three Royal Colleges have formed their own Conjoint Committee, and the two specialist committees have agreed to work together in the closest liaison for the betterment of conditions throughout New Zealand. For the first time, therefore, specialists can speak with a single clear voice. The committees are now at work on proposals for new and better relationships between the profession and its employers. It is of the utmost importance that these proposals, when presented to the authorities, should meet a sympathetic reception, and that a mechanism be found by which satisfactory working terms can be freely negotiated. The future of the hospital specialist service is in jeopardy if a solution to this problem is not soon discovered. With deterioration in present standards of hospital care, it is the patient who suffers. The responsibility of preventing this rests with the State.

*The Central Specialists' Committee was set up by the New Zealand Medical Association.

DID YOU KNOW

....ABOUT CLOSE-DOWNS?

An employer can close its operations or discontinue the work of one or more employees over the Christmas break and require employees to take annual leave. This can only be done in limited circumstances though and you are entitled to not less than 14 days' notice. If you are asked to work at any time during the close-down though (including being on call), the close-down does not apply to you. If your employer proposes a close-down, it is well worth contacting your Industrial Officer to discuss the requirements.

.... ABOUT PUBLIC HOLIDAYS?

If you would normally work on a public holiday, you are entitled to a day off on full pay. If you actually work or are on call on "any part of" any of these days, you are entitled to a day-in-lieu on full pay at a later date, plus your usual pay for the day worked, plus a loading of 50% of your "relevant daily rate" for every hour worked on the public holiday. The loading would not apply though to any existing T1.5 arrangements.

If you are a shift worker, eg, in ICU or ED, and you have a rostered day off on a public holiday, you are entitled to a day-in-lieu on full pay on another mutually convenient day.

.... ABOUT FIXED TERM EMPLOYMENT AND CME?

If you are engaged for six months or less, you are not entitled to CME expenses or leave for CME.

... ABOUT SECONDMENTS?

You are entitled to use your accrued CME expenses to support a secondment of two weeks every three years. Secondments must be to a recognised unit for the purpose of your professional development and to upgrade your skills.

...ABOUT COVERING FOR RESIDENT MEDICAL OR DENTAL OFFICERS?

Where an SMO is requested to undertake additional duties arising from the immediate and unexpected absence of an RMO, you may be entitled to extra pay for the additional work at the premium of double your hourly rate (calculated on Step 6 as a minimum).

It is important to note that such occasions are expected to be rare and the situations where this applies are limited and specific. If this is happening in your workplace, it is worth checking Clause 13.4 and talking to your Industrial Officer if you're not sure.

A colleague who speaks up before I harm a patient is helping both my patient and me.

SPEAKING UP TO PREVENT DISTAL HARM

DR LYNNE MCKINLAY (MBBS, FRACP, FAFRM.) | SENIOR MEDICAL EDUCATOR, COGNITIVE INSTITUTE

You believe in an evidence-based approach, right? Well, evidence shows that one in ten of our patients receive at least one unexpected, unwelcome, unpleasant or otherwise negative outcome of care[1]. If you observe a clinical incident unfolding and speak up to prevent the patient being unintentionally harmed, we call that a 'good catch'[2]. Graded assertiveness training, which the health sector has adopted from aviation and other high-risk industries, enables staff to speak up, and this is important[3].

As humans, it is inevitable that we will make errors and someone else is more likely to detect my mistake than I am. A colleague who speaks up before I harm a patient is helping both my patient and me.

HUMAN ERROR AND PATIENT SAFETY

Current understanding of the role of human error in patient safety recognises that human factors—people, organisational and system factors—may all contribute to patient harm. James Reason's famous 'Swiss cheese model' tells us an error will result in an incident when 'holes' in the many layers of protection designed to catch an error line up and let the error through[4].

In 1999, the publication *To Err is Human* changed the way we think about patient safety and drew a conclusion that was surprising at that time: 'that the majority of medical errors do not result from individual recklessness or the actions of a particular group - this is not a "bad apple" problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them'[5]. What the authors appear to mean by 'bad apples' are individuals who are incompetent, dangerous, reckless, impaired or uncaring, or rarely those who criminally undermine safeguards[6].

Since that landmark publication, we have systematised reporting and investigating clinical incidents, advocated for a blame-free culture, and looked for factors to change and improve safety. Some of these factors are closer in time and space to the actual harm and some are errors just waiting to happen; the latent failures which Reason called 'pathogens' within the system[4].

DISTAL HARM IN HEALTH CARE

Think about a confused patient in bed. The rails have not been put up and she is about to fall. Failure to use the bedrails might be called a 'proximate' cause of harm as there is a direct and uninterrupted relationship between the cause and the harm from falling. But there is another sort of harm that we are only now starting to understand. Distal harm results from actions not directly related to the incident, so they may be difficult to identify and difficult to prove as causative.

An important cause of distal harm that we are just starting to understand and address in a systematic way is the impact of unprofessional behaviour. A considerable body of evidence points to unprofessional behaviours and deviations in individual performance as factors which seriously undermine team function, the culture within which health professionals operate and the delivery of safe care — such behaviour can undermine a culture of safety[7].

In 2015, a publication by Catron, Hickson and colleagues demonstrated a correlation between the risk of surgical complications and unprofessional behaviour, using the number of unsolicited patient complaints made against the surgeon in charge - complaints relating to communication, respect or accessibility - as a proxy measure of behaviour[8]. For lower risk patients, there was no difference between so-called high complaint surgeons and low complaint surgeons. However, when the clinical situation became complex, the high complaint surgeons had significantly poorer patient outcomes[8].

There are a number of possible explanations for this. As the complexity of the patient or the surgery goes up, the volume and importance

of communication and the need for teamwork rises. A clinician displaying unprofessional behaviour is not only a poor role model but may induce errors, as those around them use some of their cognitive capacity to monitor for threats.

Unprofessional behaviour, whether disruptive and aggressive, or passive and undermining is a different barrel of 'bad apples' that can cause harm to patients. Those exhibiting such behaviours may not intend patient harm and may be ignorant or even shocked to learn of its impact, but the evidence certainly supports that unprofessional behaviour may result in patient harm[9].

SPEAKING UP TO PREVENT DISTAL HARM

If you notice a colleague refusing to wash their hands, taking a dangerous shortcut, demonstrating disrespect or breaking a rule, will you see it as a patient safety issue and speak up?

In a 2010 study, four out of five nurses had concerns about these 'undiscussables' but less than a third had spoken with the person who concerned them most[10]. Most of us would feel uncomfortable speaking with a colleague about their behaviour, and speaking to a friend might be even harder. In lacking the courage or the words to speak up, we may contribute to distal harm as well.

Witnessing an event in which patient harm is imminent has an urgency that may give us the courage to speak up; we know it is a 'now or never' situation. But will you, are you able to, are you expected to, speak up if you observe behaviour that is unlikely to cause harm right now, but will undermine the safety culture of your organisation if it is persistent and permitted? Will you see this as an opportunity to improve patient safety, or will you leave it and hope someone else will speak up?

A NEW APPROACH TO PROMOTING PROFESSIONALISM

We may be unable or unwilling to speak up because of fear, or uncertainty, or a power differential. We may have already tried and failed. We need another means of acting. The Vanderbilt University Medical Centre approach to promoting professional accountability, which has been adapted for the Australasian health care environment, provides an alternative[11-12]. Confidential reporting of unprofessional behaviour allows the organisation to speak up using trained peers. The programme builds on the professionalism and commitment of the overwhelming majority of staff, while ensuring the actions of no one individual can undermine a culture of safety.

CONFLICT OF INTEREST STATEMENT

Lynne McKinlay works as a Senior Medical Educator for the Cognitive Institute, part of the Medical Protection Society. The Promoting Professional Accountability Programme is delivered by Cognitive Institute.

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Cognitive Institute is part of the Medical Protection Society

An important cause of distal harm that we are just starting to understand and address in a systematic way is the impact of unprofessional behaviour.

ASMS SERVICES TO MEMBERS

As a professional association, we promote:

- the right of equal access for all New Zealanders to high quality health services
- professional interests of salaried doctors and dentists
- policies sought in legislation and government by salaried doctors and dentists.

As a union of professionals, we:

- provide advice to salaried doctors and dentists who receive a job offer from a New Zealand employer
- negotiate effective and enforceable collective employment agreements with employers. This includes the collective agreement (MECA) covering employment of senior medical and dental staff in DHBs, which ensures minimum terms and conditions for more than 4,000 doctors and dentists, nearly 90% of this workforce
- advise and represent members when necessary
- support workplace empowerment and clinical leadership.

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Have you visited our regularly updated website? It's an excellent source of collective agreement information and it also publishes the ASMS media statements.

We welcome your feedback because it is vital in maintaining the site's professional standard.

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We encourage you to recommend that your head of department and those responsible for advertising vacancies seriously consider using this facility.

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In addition to *The Specialist*, the ASMS also has an email news service, *ASMS Direct*.

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